

Registration District No. 836

Primary Registration District No. 6098A

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Stoddard Co
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Stoddard Co
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Whole life (Specify whether years, months or days) 2

8. (a) PRINT FULL NAME

Albert Walker

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 16, 1938
(Month) (Day) (Year)

8. AGE: Years 2 Months 2 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Bell City Mo. 7
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Anna Walker 1
13. Birthplace unknown 0
(City, town, or county) (State or foreign country)
14. Maiden name Martha Ballinger
15. Birthplace Bell City Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Dan Ballinger

(b) Address Bernie Mo Rt 1

17. (a) Burial (Burial, cremation, or removed) (b) Date thereof Dec. 23, 1940
(Month) (Day) (Year)

(c) Place: burial or cremation Walker Church Cemetery

18. (a) Signature of funeral director Duncan Funeral Home

(b) Address Bernie Mo

19. (a) Dec 31 1940 (Date received local registrar) (b) Laura Hopkins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stoddard Co
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Bernie Mo RR#1
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-22-40 day 12-22-40
year 40 hour 11 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from 12-18-
_____, 1940, to 12-22-_____, 1940;
that I last saw him alive on 12-22-40, 1940;
and that death occurred on the date and hour stated above.
Immediate cause of death Dysphtheria Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 893-
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Wm. Ryan (M. D. or other) 1
Address Bernie Mo Date signed 12-22-40

RECEIVED

District Health Officer

District File Number 141-

Date Filed 6/9/

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.